CONVERSION PLAN CHECKLIST
(Health Benefit Plan)

( ) Review with Basic Insurance Policy Checklist
( ) Review with Checklist for Internal Appeals/External Reviews.

Mandatory Provisions/Benefits

The following provisions must be included in the individual policies. If they do not appear, check the statute to be sure it applies to the type policy being reviewed. See KRS 304.17-300 as a general reference.

( )	KRS 304.17-030(1)	Consideration
( )	KRS 304.17-030(2)	Date and duration
( )	KRS 304.17-030(3)	Insure only one person Unmarried dependents who are full-time students are eligible for coverage on a family policy to age 25 or to age 19 for dependents not in school
( )	KRS 304.17-030(4)	No undue prominence to any portion of text
( )	KRS 304.17-030(5)	Exceptions and reductions specified
( )	KRS 304.17-030(6)	Form number
( )	KRS 304.17-042	Newborn children covered from birth. Notice of birth & premium payment may be required within 31 days of birth in order to continue coverage, if payment of specific premium or fee is required to add a child.
( )	KRS 304.17A-140	Dependent includes legally adopted/court-appointed guardian if coverage is obtained within 30 days of petition or appointment
( )	KRS 304.17-050	Entire contract
( )	KRS 304.17-060	Limitation on defenses and incontestability (3 years)
( )	KRS 304.17-070	Grace period
( )	KRS 304.17-080	Reinstatement
( )	KRS 304.17-090	Notice of claim (60 days)

( ) KRS 304.17-100 Claim forms (15 days)

( ) KRS 304.17-110 Proof of loss (90 days)

( ) KRS 304.17-120 Time of payment of claims

( ) KRS 304.17-130 Payment of claims

( ) KRS 304.17-140 Physical examination and autopsy

( ) KRS 304.17B-015 Requirements for guarantee issue
KRS 304.17B-025 GAP eligibility (Effective January 1, 2000)

( ) KRS 304.17A-580(2) Emergency medical condition definition: Prudent lay person rule and must be based on presenting symptoms. (Effective at issue or renewal after July 14, 2000)

( ) KRS 304.17A-510(1)(d) A statement regarding the effect on the Enrollee of any hold harmless agreements with providers must be included in the policy. Description of and limitation to enrollee liability.

( ) KRS 304.17A-138 Requires coverage for telehealth services (Effective at issue or renewal after July 15, 2001.)

( ) KRS 304.17-150 Legal actions (60 days to 3 years)

( ) KRS 304.17-160 Change of beneficiary

( ) KRS 304.17-170 Right to examine and return policy (10 days) (Must be on face page)

( ) KRS 304.17-270 Right to refuse renewal

( ) KRS 304.17-310 Continuance of coverage for handicapped child

( ) KRS 304.17A-220(3)(b) Enrollment date

( ) KRS 304.17A-005(6) Define prior creditable coverage

( ) KRS 304.17A-005(7) Define eligible individual (18-month previous coverage without a 63-day lapse in coverage

( ) KRS 304.17A-250(9) Health benefit plans must coordinate benefits. Must use
806 KAR 18:020 benefit reserve.

( ) KRS 304.17A-250(8) Hospice coverage must be provided at least equal to the benefits provided by Medicare

( ) KRS 304.17A-145 Maternity coverage, hospital stay requirement

( ) KRS 304,.17A-230 (1) Pre-existing conditions may not be imposed on eligible individuals
(2) Must credit prior coverage when pre-existing conditions are imposed for non-eligible individuals provided the benefits are substantially similar
(3) Genetic information may not be treated as a pre-existing condition
(4) Pregnancy may be considered a pre-existing condition
(5) Domestic violence cannot be considered a pre-existing condition

( ) KRS 304.17A-110(2)(a) Six-month look-back and 12-month pre-existing condition clause

( ) KRS 3304.17A-220(5)(a),(b) No pre-existing condition exclusion for newborn, dependents, or guardians if coverage is applied for within 31 days of eligibility

( ) KRS 304.17A-139 Automatic coverage for necessary care and treatment of medically diagnosed metabolic diseases for newborns for the first 31 days. Coverage also must be provided for amino acid modified preparations and low-protein modified food for inherited metabolic disease for conditions listed in KRS 205.560(1)(c) if prescription drugs are covered. Benefits can be limited to $25,000 per year for medical formula and to $4,000 per year for low-protein modified foods. (Effective at issue or renewal after July 14, 2002)

( ) KRS 304.17A-240(2) Guaranteed renewal of health benefit plans:
(a) non-payment of premiums;
(b) fraud or intentional misrepresentation of material fact;
(c) intentional and abusive non-compliance with plan rules;
(d) the insurer ceases to offer coverage in the individual market
(e) the insured no longer works, resides or lives within the service area when a network is used
(f) insurance is through an association and the insured is longer a member of the association

( ) KRS 304.17A-245 <u>Cancellation Requirements</u>:
(1) Requires 30 days' advance written notice of cancellation;
(2) Cancellation for non payment of premium effective to last day through which premium was paid;

(3) Return of unearned portion of premium paid;
(4) The coverage continues if 30 days' notice is not provided;

( ) KRS 304.17A-240(3) Notice requirements for termination of coverage:
(a) When the insurer discontinues a particular plan;
1. Insurer must provide 90 days' notice of discontinuance.
2. Insurer must offer to each insured with coverage of this type the option to purchase any other type of plan offered by the carrier.
3. When discontinuing coverage, the insurer must act without regard to health status.
(b) 1. When the insurer discontinues offering all health benefit plans;
a. Insurer must notify the commissioner and all insureds at least 180 days prior to discontinuance.
b. All health benefit plans must be discontinued and non-renewed.
2. Insurer cannot enter the market for five (5) years.

( ) KRS 304.17A-540 Limits and treatment, procedures, drugs or devices to be defined and disclosed in the policy or certificate and standards for claim denial letters

( ) KRS 304.17A-131 Mandated coverage for cochlear implants

( ) KRS 304.17A-143 Mandated coverage for autism ($500 monthly benefit)

( ) KRS 304.17A-148 Mandated coverage for diabetes

( ) KRS 304.17A-135 Autologous bone marrow transplantation (ABMT) for breast cancer

( ) KRS 304.17A-500(4) Insurers cannot have language that conflicts or is more restrictive than this section allows. Definition of emergency medical condition.

( ) KRS 304.17A-643(2) Special circumstances when the insured can have continued care with a same provider even though the provider is no longer participating. Treating provider must make the request with concurrence with the covered person. (Must inform insureds of when they can have continuity of care)

( ) KRS 304.17A-647(2) A female may be covered for an annual pap smear performed by an obstetrician or gynecologist without a referral from a PCP.

( ) KRS 304.17A-535(4) Must have a exception policy for plans that use a formulary.

( ) KRS 304.17A-505(j) Must make available upon request a complete formulary.

The following must be covered. If not specifically mentioned as a benefit, they may not be excluded.

( ) KRS 304.14-370 Binding arbitration cannot be required. Arbitration can be an option.

( ) KRS 304.17A-245(3) Insurers must return unearned premium.

( ) KRS 304.17A-702 Payment of claims requirements (Effective at issue or renewal after July 14, 2000.)

( ) KRS 304.17A-250(1) Standard plan coverage can be modified at renewal

( ) KRS 304.17A-005(18) Providers defined (in addition to the ones listed below) pharmacists, podiatrists, physician's assistant, nurse practitioner, and other practitioners as determined by the department by administrative regulation in 13A.

( ) KRS 304.17A-505 Disclosure of covered services, restrictions or limitations, financial responsibility of covered person, prior authorization requirements or any review requirements with respect to covered services, where and how services may be obtained, changes in covered services, covered person's right to appeal, procedures for appeal and measures to ensure confidentiality of the relationship between an enrollee and a health care provider

( ) KRS 304.17-305 Indemnity payable for services performed by optometrists, osteopaths, physicians, or chiropractors

( ) KRS 304.17A-275 Osteopaths should be defined as a covered provider. (Effective when the plan is issued or renewed after July 14, 2000)

( ) KRS 304.17-315 Policy covering services performed by dentists

( ) KRS 304.17-316 Coverage for low-dose mammography screening
( ) KRS 304.17-316(2)(b) Requires coverage for mammograms, regardless of age, for a covered person diagnosed with breast disease.

( ) KRS 304.17-317 Ambulatory surgical centers (Must be covered)

( ) KRS 304.17-319 Coverage for TMJ

( ) KRS 304.12-013	Coverage for AIDS
( ) KRS 304.17A-146	Benefits must be provided for a registered nurse first assistant if first assistance benefits are provided, provided he or she is acting within the scope of his or her license. (Effective at issue or renewal after July 14, 2000)
( ) KRS 304.17A-641(1)	An insurer that requires prior authorization for poststablization treatment in an emergency care situation at a non participating hospital, approval or denial shall be provided in a timely manner, but in no case to exceed two hours from the time request has been made and all relevant information provided. Failure to provide timely approval shall constitute approval.
( ) KRS 304.17A-645	A PCP treating a person with a chronic, disabling, congenital, or life threatening condition may authorize a referral to a participating non PCP specialist, up to 12 months or for the contract period, whichever is shorter.
( ) KRS 304.17A-1473	Coverage must be provided for services of a physician assistant if coverage is provided for surgical first assisting or intraoperative surgical care benefits or services (Effective for health benefit plans issued or renewed on or after July 15, 2001).
( ) KRS 304.17A-647	Insurers cannot prohibit a PCP from referring a covered person who is pregnant or has a chronic gynecological condition to authorize a referral to a participating obstetrician or gynecologist for up to 12 months or for the contract period, whichever is shorter.
( ) KRS 304.17A-149	Requires coverage for payment of anesthesia & hospital or facility charges in connection with dental procedures for children below the age of nine, persons with serious mental or physical conditions, & persons with significant behavioral problems, in all health benefit plans that provide coverage for general anesthesia & hospitalization services.
( ) KRS 304.17A-132	Requires coverage for hearing aids and related services for persons under 18 years of age for the full cost of one hearing aid per impaired ear up to $1,400 every 36 months.

Minimum Benefits

( ) KRS 304.18-120(1)	Lifetime maximum benefit cannot be less than $500,000

( ) 806 KAR 17:260, Section 2	Plan Cost Sharing not to exceed; $6,000 for individual, $12,000 for family, for HMO or POS product; $6,000 deductible & $6,000 out-of-pocket limit for an individual, $12,000 deductible & $12,000 out-of-pocket limit for a family, for a FFS or PPO product.
( ) 806 KAR 17:260, Section 3(1), (HMO & POS Products)	In-hospital care—$1,000 maximum co-pay room & board per admission.
	Transplants—$1,000 maximum co-pay per admission
	Outpatient surgery—$500 maximum co-pay per visit
	Provider office visits—$30 maximum co-pay per visit
	Diagnostic tests—$30 maximum per testing session.
( ) 806 KAR 17:260, Section 3(1)(c)	Emergency care—$150 maximum emergency room per visit, $75 maximum ground ambulance per use
	Hospice care—same as Medicare benefit
( ) 806 KAR 17:260, Section 3(2), (FFS& PPO Products)	In-hospital care—50% maximum coinsurance room & board
	Transplants—50% maximum coinsurance
	Outpatient surgery—50% maximum coinsurance
	Provider office visits—50% maximum coinsurance
	Diagnostic tests—50% maximum coinsurance
	Emergency care—50% maximum coinsurance emergency room visits, 50% maximum coinsurance ground ambulance
	Hospice care—same as Medicare

Optional Provisions

The following provisions may be included. See KRS 304.17-300 as a general reference.

( ) KRS 304.17-190	Change of occupation
( ) KRS 304.17-200	Misstatement of age
( ) KRS 304.17-210	Other insurance in this insurer
( ) KRS 304.17-220	Insurance with other insurers

KRS 304.17-230

( ) KRS 304.17-240 Relation of earnings to insurance

( ) KRS 304.17-250 Unpaid premium

( ) KRS 304.17-260 Conformity with state statutes

( ) KRS 304.17-280 Illegal occupation

( ) KRS 304.17-290 Use of intoxicants

( ) 806 KAR17:030 Indemnification for surgical care by use of a schedule:

A. If indemnification is limited to the listed operations, the policy or rider shall so indicate in the unequivocal language.

B. If the company is to determine the amount to be paid for any unlisted operation, the policy must provide how that amount will be determined.

Required Offerings

( ) KRS 304.17-185 Nursery care for well newborns

( ) KRS 304.17-313 Home health care (Must cover a minimum of 60 visits per year)

( ) KRS 304.17-318 Mental illness

( ) KRS 304.17A-135 Treatment of breast cancer

( ) KRS 304.17A-134
( ) KRS 304.17-3163 Breast reconstruction surgery (Effective at issuance or renewal on or after 7-14-02), treatment for endometriosis and endometritis, and bone density testing Mastectomy cannot be required on an outpatient basis.

Prohibited Provisions

( ) KRS 304.5-160 No health insurance contract shall cover abortion except by rider.

( ) KRS 304.17-030(7) Incorporation by reference of charter, rules, constitution, or by-laws of insured

( ) KRS 304.17-360 Benefits or values for surviving or continuing policyholders contingent upon termination or lapse of other policyholders

( ) 806 KAR 17:050 Limit or exclude obligation to pay because insured is

eligible for or receiving Medicaid

( ) KRS 304.12-135 Must pay claims within 30 days
KRS 304.17A-702

Requirements not necessarily in the policy.

( ) KRS 304.17A-250(7) Comparison form

( ) KRS 304.17A-607 Timeframes for UR decisions
Section 1 (h) & (i)

( ) KRS 304.17A-150 *Anyone marketing insurance cannot encourage any consumer not to file an application for health insurance with another carrier because of health status.
*Insurers cannot encourage any consumer to apply for health insurance with another carrier because of health status.
*Insurers cannot encourage an employer to exclude an employee from coverage.
*Insurers are prohibited from compensating any person marketing insurance on the basis of health status.
*Insurers must compute the insured's coinsurance or cost sharing on the basis of the amount received by a healthcare provider from the insurer.